

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11132

CERTIFICATE OF DEATH

11125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CALVERT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville 18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CALVERT NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAURA Middle M. Last BEBEE		4. DATE OF DEATH Month OCT. Day 22 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 21, 1887
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zack S. Graves		14. MOTHER'S MAIDEN NAME Jane E. Biscoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. L. Graves - Mechanicsville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH, 30 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARALYSIS AGITANS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 1, 1958 , to OCT. 22, 1958 , that I last saw the deceased alive on OCT. 14, 1958 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Merle L. Gibson Jr. M.D.		ADDRESS (Street, city or town, state) Prince Frederick Md	
DATE SIGNED 10/25/58			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-25-58	
22c. NAME OF CEMETERY OR CREMATORY MT. ZION		22d. LOCATION (City, town, or county) (State) LAUREL GROVE, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson - Leonardtown Md		ADDRESS	
24a. REC'D BY REGISTRAR OCT 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

11135

11135

Form with multiple lines for handwritten entry, including fields for name, age, sex, date of death, and cause of death. The text is mostly illegible due to fading and bleed-through.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

111133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11126

Item 1D Film C 235 10/31/58 gg

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u> c. LENGTH OF STAY in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Victoria</u> d. STREET ADDRESS <u>08X-2</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Clark</u> Middle <u>Clark</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24 1877</u> yrs. <u>81</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John W Clark</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Blackhall</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-32-2194</u>		17. INFORMANT <u>Mrs. Magdalene Shale</u> Address <u>906-Liberty St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> 442X DUE TO <u>Cyc</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Jumping of rt leg</u> DUE TO (c) <u>1 hr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. W.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crown Burial Home Mt Victoria</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		24a. REC'D BY REGISTRAR <u>OCT 29 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

11134 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 235 10-21-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> c. LENGTH OF STAY IN 1b <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachel</u> First <u>Coates</u> Middle <u>Ernest</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1862</u>	9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H W</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Ben Smith</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ernest Coates</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer vascular remodeling</u> 442x DUE TO (b) <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bed sitting in Chair at home</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H W Wang</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>	
				22d. LOCATION (City, town, or county) <u>Sunderland</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Prince Frederick</u>		24a. REC'D BY REGISTRAR <u>Oct 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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HYPAD TO STAGWINDS ZEPHYRUS LADIES' TEAM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11135

CERTIFICATE OF DEATH

Reg. Dist. No.

11128

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>X</u> Willows			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Audrey Gregory</u>				4. DATE OF DEATH Month Day Year <u>October 6 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1886</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Mays</u>				14. MOTHER'S MAIDEN NAME <u>Willie McGrow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Audrey Gregory, Willows, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 3</u> , 19 <u>58</u> , to <u>Oct. 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 6</u> , 19 <u>58</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Merle L. Gibson Jr.</u> M.D. <u>Prince Frederick, Md.</u> PHYSICIAN'S NAME (Type) <u>Merle L. Gibson, Jr., Prince Frederick, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematorium</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lee Funeral Home - Washington D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll S. Evans</u>	

CERTIFICATE OF DEATH

Form No. 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11136
CERTIFICATE OF DEATH

11129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabaret</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Cabaret</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>				c. LENGTH OF STAY IN 1b <i>Life</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>				d. STREET ADDRESS <i>—</i>			
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>R.</i> Last <i>Grover</i>				4. DATE OF DEATH Month <i>Oct.</i> Day <i>27</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 23, 1876</i>	9. AGE (In years last birthday) <i>82</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Building</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Cabaret Co., Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert R. Grover</i>				14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Wells</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-0706</i>		17. INFORMANT <i>Kennedy Grover - Solomons, Ind</i> Address <i>—</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> <i>177X</i> DUE TO <i>Ca of prostate</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>19</i> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Jan</i> 1957, to <i>10/27</i> , 1958, that I last saw the deceased alive on <i>Oct 27</i> , 1958, and that death occurred at <i>M</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. de Villareal</i> M.D.				ADDRESS (Street, city or town, state) <i>St Leonard</i> DATE SIGNED <i>10/58</i>			
PHYSICIAN'S NAME (Type) <i>R. de VILLAREAL</i>				ST. LEONARD			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Oct. 29, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Paul's Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Rushy Cabaret Co., Ind</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>A.A. Harkness & Son - Mutual, Ind.</i> ADDRESS <i>—</i>				24a. REC'D BY REGISTRAR DATE <i>OCT 31 58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

11137 CERTIFICATE OF DEATH

11130

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>D.</u> Last <u>Hooks</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9,</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>marl and</u>	9. AGE (In years last birthday) <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles A. Hooks</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Murray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>317-32-465</u>	
17. INFORMANT <u>Hattie Hooks</u>		Address <u>St. Leonards Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4 a.m.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1951</u> to <u>Oct 15, 1958</u> , that I last saw the deceased alive on <u>Oct 14, 1958</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. E. Sewell</u> M.D.		DATE SIGNED <u>Oct 15, 1958</u>	
PHYSICIAN'S NAME (Type)			
22a. (BURIAL) CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-18, 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooks</u>	22d. LOCATION (City, town, or county) (State) <u>Island Creek, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 1958</u>	
ADDRESS <u>Prince Frederick</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. P. 100-10</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—DEATH, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11131

11138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u> </u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Norman Lee Hooper</u>				4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/42</u>		9. AGE (In years last birthday) <u>16</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>			
13. FATHER'S NAME <u>William A. Hooper Jr</u>				14. MOTHER'S MAIDEN NAME <u>Lucille Hood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>William A. Hooper Jr, Prince Frederick Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>traumatic death</u> DUE TO (b) <u>Wheat, Hoe to in the road</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>car rolled into a pond</u>					
20c. TIME OF INJURY Month, Day, Year <u>10/22/58</u> Hour <u>4:42</u> p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
20f. (City or town) <u>Prince Frederick</u> (County) <u>Calvert</u> (State) <u>Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H. L. H. H.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/22/58</u>			
EXAMINER'S NAME (Type) <u>A. A. Harkness</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 25, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Central Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Barstow</u> (State) <u>Calvert Co. Md.</u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness</u>		ADDRESS <u> </u>		DATE <u>OCT 27 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11139

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Quintion</i> Middle <i>M</i> Last <i>Mackall</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>12</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>25 May 1953</i>
9. AGE (In years last birthday) <i>5</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph D Mackall</i>		14. MOTHER'S MAIDEN NAME <i>Melvinia V. Dillon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition dehydration</i> 7856 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diarrhea</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>J. J. Weems</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 13, 58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Edwards Church</i>		22d. LOCATION (City, town, or county) (State) <i>Chesapeake Beach, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leroy E. Berry</i>		24a. REC'D BY REG-STRAR DATE <i>OCT 15 58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles E. Howard</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11140

CERTIFICATE OF DEATH

11133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Fred</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Fred, Md</u>	
		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Mason</u> Last <u>Mason</u>		4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Jefferson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
		17. INFORMANT <u>Mrs. Selma Joye Prince Fred, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>231X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Death on Arrival</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9th</u> , 19 <u>58</u> , and that death occurred at <u>9th</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Merle L. Gibson Jr. M.D.</u>		PHYSICIAN'S NAME (Type) <u>Prince Frederick Md</u>	
22a. (BURIAL) CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-8-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Fred, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sawell</u> ADDRESS <u>Prince Fred, Md</u>		24a. REC'D BY REGISTRAR <u>OCT 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>C. W. ...</u>

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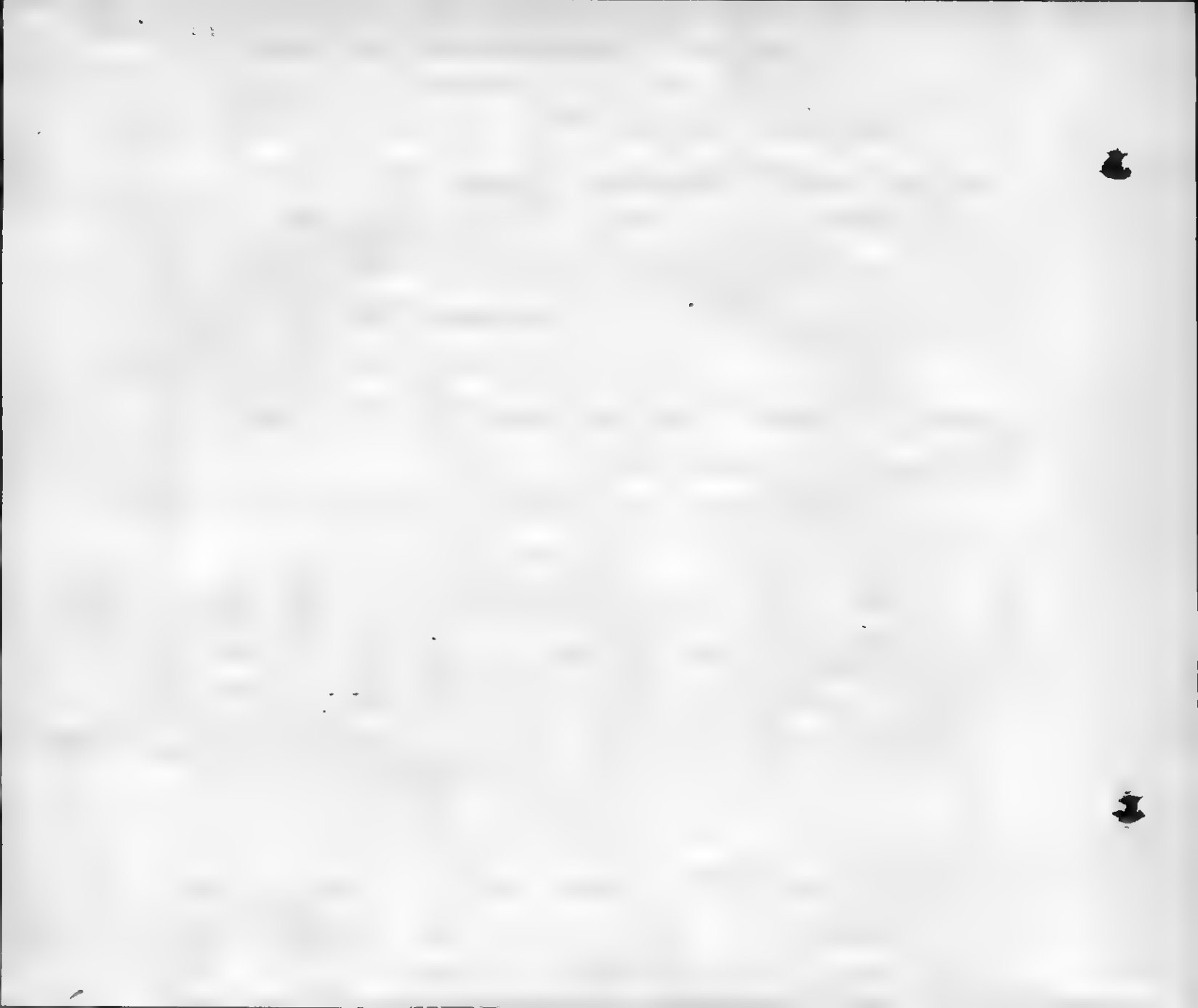
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|------------------------------|---|------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Wheat</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Wheat</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Frederick</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Frederick</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>CHARENCE CO.</u> | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Charles</u> Middle <u>Walter</u> Last <u>Wheat</u> | | | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>27</u> Year <u>1978</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>15/1900</u> | | 9. AGE (In years last birthday)
<u>58</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Engineer</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John H. Wheat</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Esther E. Wheat</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-16-4544</u> | | 17. INFORMANT
<u>Frederick B. Wheat</u> Address <u>Frederick</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(c) <u> </u>
DUE TO
(a), stating the underlying cause last. (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>None</u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> o. m. <u> </u> p. m. <u>12</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>H. W. Ward</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>H. W. WARD</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Buried</u> | | 22b. DATE THEREOF
<u>Oct. 26, 1978</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Greenwood Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore - Cecil Co. - Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>G. O. Tarkenton & Son - Mutual, Md</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>OCT 27 '78</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11142

11135

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|--|--|---|---|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>CALVERT</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY <u>CALVERT</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>PRINCE FREDERICK 11/2</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Prince Frederick</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>ANNA</u> <u>MARIE</u> <u>MYERS</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>Oct. 24, 1958</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u> | 8. DATE OF BIRTH
<u>JULY 26, 1914</u> | 9. AGE last birthday
<u>44</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>215-05-7568</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>PETER SWIESKOSKI</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Nasek</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>215-05-7568</u> | | 17. INFORMANT & ADDRESS
<u>Milton F. Myers, Jr. (son)</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 1. <input checked="" type="checkbox"/> IMMEDIATE CAUSE
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | (A) <u>Metastatic Carcinoma of Lung</u>
(B) <u>Carcinoma of Breast</u>
(C) | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 mo.</u>
<u>1 yr.</u> | |
| 19a. DATE OF OPERATION
<u>Jan. 1958</u> | | 19b. MAJOR FINDINGS OF OPERATION
<u>Carcinoma of Breast</u> | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Night <input type="checkbox"/> | | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Oct. 1, 1958</u> , to <u>Oct. 24, 1958</u> , that I last saw the deceased alive on <u>Oct. 24, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>M. L. Gibson Jr.</u> | | | | ADDRESS (Street, city, town, state)
<u>M.D. Prince Frederick Md.</u> | | DATE SIGNED
<u>10/24/58</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>BURIAL</u> | | DATE THEREOF
<u>10-27-58</u> | | NAME OF CEMETERY OR CREMATORY
<u>HOLY ROSARY</u> | | LOCATION (City, town, or county) (State)
<u>BALTIMORE Co. MD</u> | |
| 24. REC'D BY REGISTRAR
DATE <u>OCT 27 58</u> | | REGISTRAR'S SIGNATURE
<u>Robert A. ...</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>John H. Weber</u> | | ADDRESS
<u>401 J. Chester St</u> | |



11143

CERTIFICATE OF DEATH

11136

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH
o COUNTY <u>Cabaret</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o STATE <u>Maryland</u> COUNTY <u>Cabaret</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fusby</u> | | c. LENGTH OF STAY IN TB
<u>Life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fusby</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>-</u> | | | | d. STREET ADDRESS
<u>-</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>HOWARD</u> Middle <u>J.</u> Last <u>PARDOE</u> | | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>20</u> Year <u>1958</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 6, 1883</u> | 9. AGE (In years last birthday)
<u>76</u> yrs. | IF UNDER 1 YEAR: Months <u>76</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | IF UNDER 24 HRS: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Postmaster</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Cabaret County, Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>James Pardoe</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Jane Buckler</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-40-8348</u> | | 17. INFORMANT
<u>Wyatt Pardoe - Fusby, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Bowel</u>
<u>153.9</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 mos</u>
DUE TO (c) <u>5 mos</u> | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>58</u> , to <u>Oct 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 20</u> , 19 <u>58</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Merle L. Gibson Jr</u> M.D. | | | | ADDRESS (Street, city or town, state)
<u>Prince Frederick, Md</u> | | DATE SIGNED
<u>10/22/58</u> | |
| PHYSICIAN'S NAME (Type)
<u>MERLE L. GIBSON JR.</u> | | | | <u>PRINCE FREDERICK, MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Oct. 23, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Middleham Chapel</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Fusby - Cabaret Co - Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>A. A. Warkner & Son - Mutual, Md</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>OCT 24 '58</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11144

11137

Reg. Dist. No.

| | | | |
|--|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ches. Beach MD</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. H</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Jessie</u> First <u>Robertson</u> Middle <u>Robertson</u> Last <u>Robertson</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/11/81</u> |
| 9. AGE (In years birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u> | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Thomas W. Shelton</u> | | 14. MOTHER'S MAIDEN NAME <u>Louise E. Jones</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. <u>579-220028</u> | |
| 17. INFORMANT <u>John Robertson Ches. Beach MD</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u>
<u>104.0</u> DUE TO (b) <u>fractured hip</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>fell at home and fractured hip</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>37 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fell at home and fractured hip</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell at home</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>9/12</u> 1958 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Ches. Beach MD</u> (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| 22a. SIGNATURE <u>H W Ward</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22b. DATE THEREOF <u>10-22-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u> | |
| 22d. LOCATION (City, town, or county) <u>4/101</u> | | (State) <u>Smithsonian Rd. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Antonia's Funeral Home - Ches. Md.</u> | | 24a. REC'D BY REGISTRAR <u>28 59</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <u>1/24/59</u> | |

Replacement: Film 238 - 1-28-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

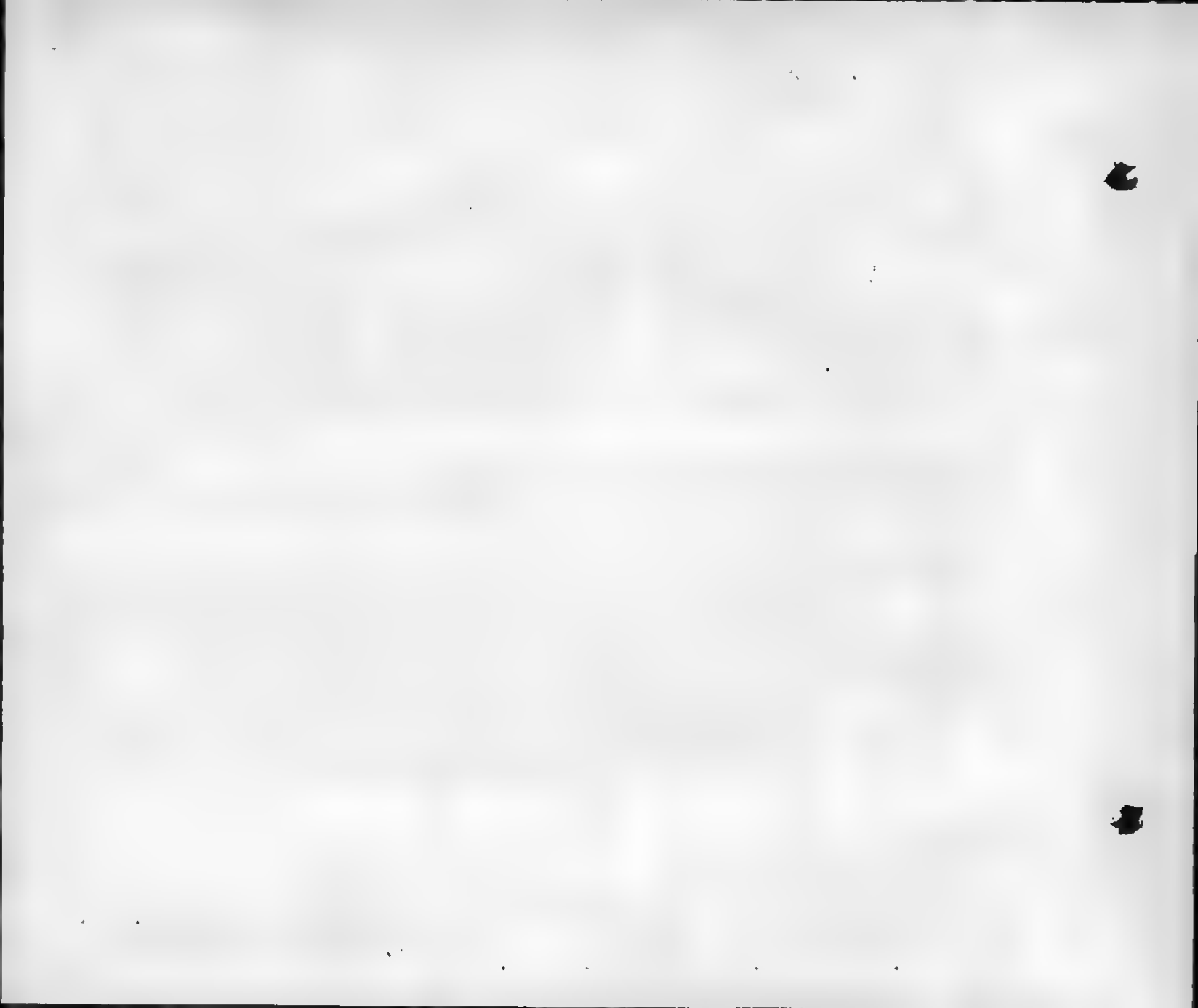
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11138

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Deale</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard's</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u> ✓
d. STREET ADDRESS <u>4312 Chesapeake Blvd</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Joseph</u> Middle <u>A.</u> Last <u>Roasco</u>
4. DATE OF DEATH
Month <u>10</u> Day <u>4</u> Year <u>1958</u> | | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>3/1/90</u>
9. AGE (In years last birthday) <u>68</u> yrs.
IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Gov. Printing Office</u>
10b. KIND OF BUSINESS OR INDUSTRY
<u>Gov. Printing Office</u>
11. BIRTHPLACE (State or foreign country) <u>WASH. DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | 13. FATHER'S NAME
<u>BARTHELOMEW</u>
14. MOTHER'S MAIDEN NAME
<u>MAGDELINE CROVO</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>AC</u>
17. INFORMANT
<u>Mrs. Mageline H. Brodt - 4812 Chesapeake Blvd</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute dilatation of heart</u>
DUE TO (b) <u>Coronary occlusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Dropped dead on shore of Ches. Bay</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Had head injury of type</u> | | 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> a. m. <u>19</u> p. m.
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>H. W. Ward</u>
EXAMINER'S NAME (Type) | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/8/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Prince Georges Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>The S. H. Hines Co. Washington, D. C.</u> | | 24a. REC'D BY REGISTRAR
<u>OCT 8 58</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Wm. S. Frank</u> | | DATE SIGNED
<u>10/4/58</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11139

11146

| | | | |
|---|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Calvert</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> | | c. LENGTH OF STAY IN 1b <u>4 months</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>11</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Robert L. Smith</u> | | 4. DATE OF DEATH <u>10</u> <u>26</u> <u>19</u> <u>58</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 19, 1908</u> |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | IF UNDER 1 YEAR <u>4</u> Months <u>26</u> Days <u>19</u> Hours <u>58</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Robert L. Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Marion Jackson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Robert L. Smith</u> | | Address <u>11</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>491X</u>
DUE TO <u>13</u>
Conditions, if any, which gave rise to immediate cause (b) <u>13</u>
DUE TO <u>13</u>
causing the underlying cause lost. (c) <u>13</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>16</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Immediate death</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u>
Hour <u>10</u> a. m. <u>26</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>F. W. Ward</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/28/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Edmunds Church</u> | | 22d. LOCATION (City, town, or county) (State) <u>Sunderland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Zeroye C. Berry</u> | | 24. REC'D BY REGISTRAR <u>OCT 29 '58</u> | |
| ADDRESS <u>Huntingtown, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |



11147 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | | | c. LENGTH OF STAY IN b 18 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Randall Cliffs Md. | | | |
| | | | | f. STREET ADDRESS 1 | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Margaret Middle Wenzel Last Wenzel | | | | 4. DATE OF DEATH
Month October Day 25 Year 19 58 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 9, 1910 | |
| 9. AGE (In years last birthday) 47 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 11. BIRTHPLACE (State or foreign country) Alabama | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Thomas Robinson | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO — | | 17. INFORMANT Forest Wenzel | | Address Randall Cliffs, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cirrhosis of liver.
581.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year, Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8 Oct , 19 58 , to 25 Oct , 19 58 , that I last saw the deceased alive on 25 Oct , 19 58 , and that death occurred at 11 P. M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Huntingtown, Md DATE SIGNED 26 Oct 58 | | | | | | | |
| ACTUAL SIGNATURE G. J. Weems | | | | PHYSICIAN'S NAME (Type) G. J. Weems | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-28-58 | | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 22d. LOCATION (City, town, or county) (State) Bladenburg Rd. Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home (Wingom) | | | | ADDRESS 4 WINGOM | | 24a. REC'D BY REGISTRAR DATE OCT 28 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE S. S. King | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11148

CERTIFICATE OF DEATH

Reg. Dist. No.

11141

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dunkirk</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dunkirk</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First <u>Elizabeth</u> Middle <u>Whittington</u> Last | | 4. DATE OF DEATH
Month <u>10</u> Day <u>26</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 26,</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel Jones</u> | | 14. MOTHER'S MAIDEN NAME <u>Charlotte Hobbs</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Harriett Smith</u> Address <u>Dunkirk, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>coronary artery disease</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>home</u> , 195 <u>5</u> , to <u>Oct 21</u> , 195 <u>8</u> , that I last saw the deceased alive on <u>Oct 10</u> , 195 <u>8</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D. | | DATE SIGNED <u>10-21-58</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>10-28-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Halls Creek</u> | 22d. LOCATION (City, town, or county) (State) <u>Dunkirk Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Frederick</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u> | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

County of Suffolk

City of Boston

Residence of Deceased

Age of Deceased

Married

Single

Sex

Male

Female

Color

White

Birth Date

Birth Place

Place of Death

Cause of Death

Immediate Cause

Underlying Cause

Registered on 10-20-20

Signature

Date

Registrar General

CERTIFICATE OF DEATH

11142

Reg. Dist. No.

11149

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Calvert MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Calvert | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Prince Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Plum Point | |
| c. LENGTH OF STAY IN 1b
5 days | | d. STREET ADDRESS ---- | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Calvert County Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Baby Boy Middle Wills Last Wills | | 4. DATE OF DEATH
Month October Day 25 Year 19 58 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/21/58 |
| 9. AGE (In years last birthday) yrs. 5 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
James Wills | |
| 14. MOTHER'S MAIDEN NAME
Shirley Jones | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mother | |
| 18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Premature (2 lb - 12 oz)
776x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Breach presentation)
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Oct 22, 1958 to Oct 25, 1958 , that I last saw the deceased alive on Oct 25, 1958 , and that death occurred at M , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R. E. Sewell | | DATE SIGNED 5th November | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF
10-26-58 | 22c. NAME OF CEMETERY OR CREMATORY
Plum Point | 22d. LOCATION (City, town, or county) (State)
Calvert Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE
P. E. Sewell | | 24a. REC'D BY REGISTRAR
DATE OCT 31 '58 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2064204XVI

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

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